INTERIM HRSA STATE PLANNING GRANT REPORT FOR ARIZONA

GRANT NO. 6 P09 OA 00001-01 R1
(Grant Period March 1 – September 30, 2001)

Prepared by Arizona Health Care Cost Containment System Administration

October 31, 2001

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EXECUTIVE SUMMARY

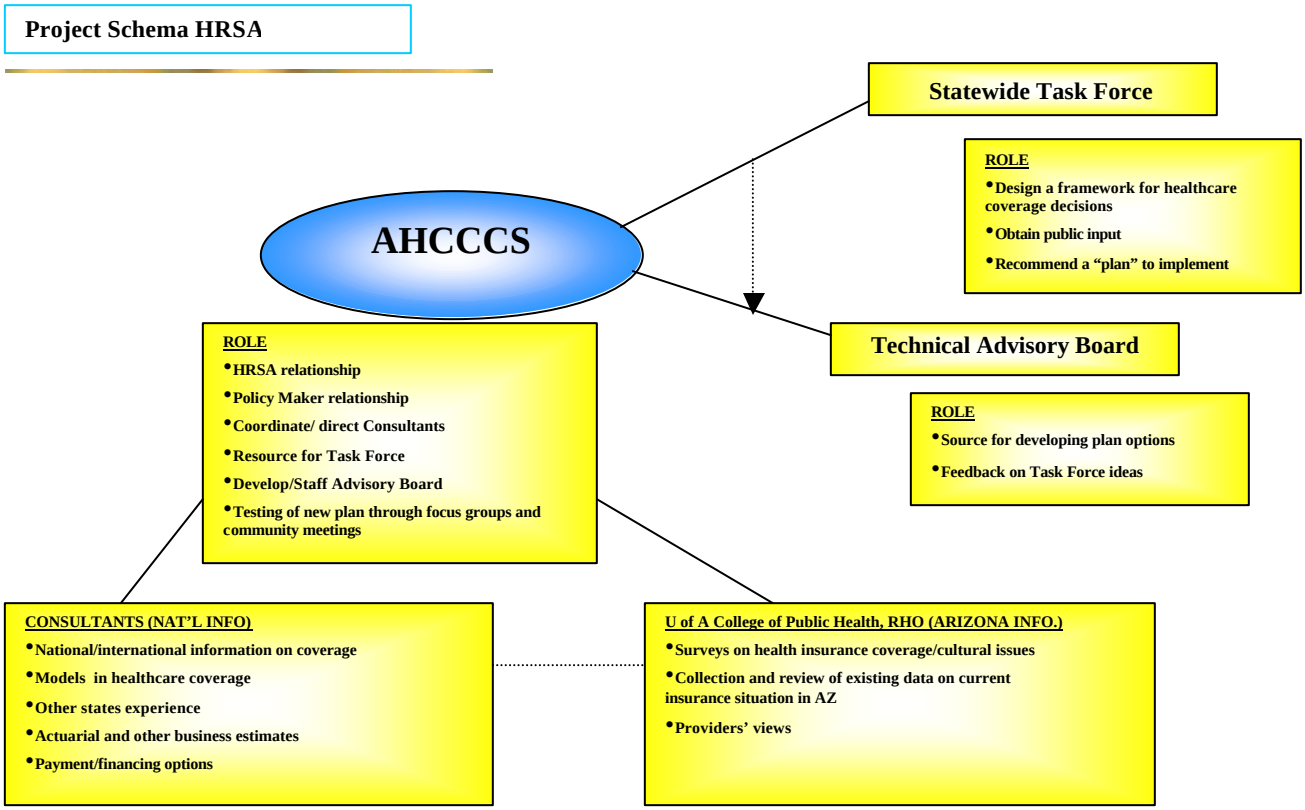
While historically Arizona has had one of the higher uninsurance rates in the nation, recently released U.S. Census Bureau data indicates that Arizona has made progress in improving health coverage in Arizona. Continual progress is being made in closing this gap in coverage with the recent implementation of several programs which receive public funds (e.g., Proposition 204 (i.e., 1115 waiver expansion), premium sharing expansion, and a drug benefit program). Additionally, HB 2050 which was passed during the 2000 legislative session created a nine member Task Force charged with the development of an affordable health care insurance plan for all Arizonans by December 2001. Unlike many states which have focused principally on the uninsured, the State has taken a broader approach by focusing both on those individuals who currently are uninsured as well as those who have coverage but are continually being confronted with issues of accessibility, comprehensiveness and affordability which may ultimately lead to a lack of coverage.

In order to effectively support and augment Arizona's efforts to address the issue of affordable, accessible health coverage, the State submitted through the efforts of the University of Arizona, Rural Health Office, a State Planning Grant application to the Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS). In March 2001, the State of Arizona became the recipient of a one year $1.16 million dollar HRSA State Planning Grant to facilitate the development of a plan for providing Arizonans with affordable, accessible health insurance.

The Arizona Health Care Cost Containment System Administration (AHCCCSA), serving as the lead agency for the project, immediately put in place an organizational structure which involved:

- Provision of technical and staffing support to the Arizona's Statewide Health Care Insurance Plan Task Force.
- Establishment of a Technical Advisory Committee of health care experts who are providing guidance in the development of options as well as feedback on proposed approaches.
- Engagement of the University of Arizona, Rural Health Office (RHO) to compile information on health care coverage in Arizona.
- Ongoing engagement with various national consulting firms to provide technical support such as development of policy briefs on national/international strategies to address health care coverage issues, actuarial and financial analyses.

A more detailed explanation of individual roles and responsibilities can be found in the Project Schema for the State Planning Grant (see next page).



Activities/Accomplishment to Date

The project has only recently moved into the phase of identifying possible strategies to be employed to address the issue of health coverage in Arizona. The primary focus over the past six (6) months has been three fold: 1) solidification of the necessary infrastructure to support the grant, 2) research, analysis and preparation of background information and 3) staffing and facilitation support for Task Force and Technical Advisory Committee meetings. A brief description of the activities and accomplishments in each of these areas is provided below.

Project Infrastructure

Phyllis Biedess, AHCCCS Director, is serving as the principal investigator for the project. Other AHCCCSA staff have also been selected to be part of the project team. Michal Goforth fills a key role as the AHCCCS-HRSA Coordinator. Two new positions were established as a result of the grant: project administration associate and provider relations/model development specialist. Lisa Dominguez and Anna Shane respectively were hired into these positions. In addition to these three individuals, C. J. Hindman, M.D., AHCCCS Chief Medical Officer and Lynn Dunton, Assistant Director of Policy were identified as key AHCCCS advisors; providing ongoing guidance with regard to the project direction. Aside from AHCCCSA staff, AHCCCSA contracted with Linda Huff Redman, Ph.D., a management health care consultant to serve as the

Project Director and David Griffis, Griffis Consulting, to serve as a facilitator for various project related meetings, e.g., Task Force meetings. In July, AHCCCSA added a component to the AHCCCS home Web site for the AHCCCS-HRSA State Planning Grant project (see www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA). All project related information is posted on the Web site (e.g., meeting minutes and policy issue papers).

Background Information

To assist the Task Force members in the identification of the most appropriate strategies for addressing the issue of affordable and accessible health care coverage, a key focus of the project grant has and continues to be the education of the policy makers through the synthesis of information, collection of data, preparation of briefing papers and formal presentations. This effort has included both a national as well as a local focus.

National Perspective

The national perspective involved the development of seven (7) policy issue papers, including where appropriate, a summary of current approaches/best practices being used by other states and their experience, an evaluation of the pros and cons of the approach(es) in the context of the guiding principles developed by the Task Force and the identification of issues that need to be considered in adopting various approach(es). The topics for these papers were selected by the Task Force members based on a suggested list provided by AHCCCSA. The briefing papers were completed by Milliman USA Inc. (first four papers listed below) and by William M. Mercer, Inc. (last three papers listed below) and included the following:

- *Purchasing Pools* focuses on purchasing pools established for small employee groups and individuals/families and their effectiveness in improving access and affordability to health insurance.
- *High-Risk Pools* examines the types of risk pools implemented by other states to cover residents whose medical costs preclude them from obtaining coverage at affordable prices in the private market.
- *Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage* provides an overview of incentives that have been implemented by other states to increase private health insurance coverage as well as provides commentary on the effectiveness of legislative mandates at the state level. Strategies examined include: those targeted at the consumer (e.g., tax credits, premium sharing, discount cards), health plan/insurance company (e.g., premium tax, mandated rural coverage, premium regulation, limits on waiting periods) and employers (e.g., tax credits, mandated payroll deductions for those employees participating in health insurance program).
- *International Approaches to a Socialized Insurance System* provides a brief overview of the socialized medicine approach to the delivery of health care that has been operating in European and other select countries.
- *Faces of the Uninsured and State Strategies to Meet Their Needs* identifies and describes the key sub-populations that one needs to consider in addressing the issue of

accessible and affordable health care coverage (e.g., low-income uninsured, working uninsured, rural uninsured) as well as a brief discussion of strategies used by states to address the needs of the specific sub-populations.

- *Initiatives to Improve Access to Rural health Care Services* provides an overview of strategies that have been implemented by other states to increase access to health care in rural areas both in terms of increasing coverage and enhancing provider networks.
- *Arizona Basic Health Benefit Plan: A Comprehensive Review* examines the Arizona Basic Health Benefit Plan in the context of other states' approaches and critiques the plan in terms of benefit design variables as well as its overall affordability.

In response to additional requests from the Task Force at the last September Task Force meeting, AHCCCSA has asked the actuarial firm of William M. Mercer, Inc. to prepare three (3) briefing memorandum addressing the following issues: 1) self-insurance, what does it mean and what are its advantages and disadvantages, 2) how does increasing premiums impact health care coverage (e.g., elasticity and demand) and 3) what are the major components driving administrative insurance costs.

Arizona Perspective

In order gain a more thorough understanding of Arizona's health care coverage and health insurance landscape, AHCCCSA engaged the University of Arizona, College of Public Health, Rural Health Office (RHO) to research, analyze and prepare an Assessment of Arizona's Health Care Coverage Report. This report will examine:

- Population characteristics and employer composition at both the state and county level
- Available health care coverage options in Arizona in 2000 and multi-year trends
- Characteristics of Arizona's uninsured population
- Costs associated with health insurance coverage in Arizona
- Strategies employed in Arizona health care market to overcome barriers to coverage

The report will be submitted to AHCCCSA by the beginning of December.

Other papers which have been prepared to date addressing Arizona specific issues include the following:

- As a complement to the policy briefing paper developed by William M. Mercer, Inc. (*Initiatives to Improve Access to Rural Health Care Service*), AHCCCSA completed a paper which provides an inventory of the strategies that have been implemented in Arizona to address rural health care infrastructure issues.
- William M. Mercer Inc., completed a paper which examined the cost impact of recently enacted health insurance mandates in Arizona, e.g., direct access to chiropractic services, standing referral requirement, and access to medical supplies.

Committee Support

Statewide Health Care Insurance Plan Task Force

Since receiving the grant, the Task Force has had three (3) meetings at which AHCCCSA played a lead role in the provision of technical assistance and staffing support. (Note: prior to the grant, the Task Force had held two meetings (i.e., 11/30/00 and 1/5/01) at which various individuals made presentations on health care coverage and programs in Arizona). The following provides a brief description of the three (3) most recent meetings. (Actual meeting minutes for the Task Force can be found at http://www.azleg.state.az.us/iminute/iminutelinks.htm.):

- May 14, 2001: Overviews were provided regarding 2001 health care coverage related legislation, the State Planning Grant and Medicaid expansion up to 100% of the Federal Poverty Level (FPL) (i.e., Proposition 204 implementation). The key focus of the meeting was the development of an agreed upon set of basic principles for health care coverage in Arizona which are intended to serve as the framework for guiding the Task Force in the formulation of final recommendations. David Griffis facilitated this discussion which resulted in six (6) basic principles:

  - We should seek to make available basic benefits
  - Health care should be available and accessible
  - Health care should be affordable and properly financed
  - Health care should be provided through a seamless system
  - Health care should be done in collaboration and in cooperation with the various stakeholders, both public and private sector and it should foster competition
  - Public private partnerships should be sought

  Each of these guiding principles was accompanied by a set of specific questions (criteria) which have and will be reviewed when developing issue papers, strategies, models, etc. (See the AHCCCS-HRSA Web site for a copy of the Statewide Health Care Insurance Plan Task Force Guiding Principles).

- August 23, 2001: AHCCCSA provided a brief update on the implementation of all the new expansion programs it will be implementing this year. The key focus of this meeting was the presentations by the AHCCCSA contracted consultants (i.e., William M. Mercer, Inc. and Milliman USA, Inc.) on the seven (7) policy issue papers that they had prepared (see Sections 2 and 3 for a brief summary of the papers). From these presentations, Task Force members discussed possible strategies for addressing the issue of health care coverage in Arizona including:
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  - Targeting of small employer groups, individuals residing in rural areas of the state and the pre-retirement group
  - Development of purchasing pools potentially building upon the existing HealthCare Group program
  - Development of a high risk pool

- Development of additional strategies to address health care infrastructure issues in rural areas of the state

- September 27, 2001: AHCCCSA reviewed a series of diagrams that portrayed health coverage in Arizona, with a specific focus on publicly sponsored coverage and a diagram summarizing rural health care infrastructure strategies (see the AHCCCS-HRSA Web site for copies of these diagrams). Based on Task Force inquiries AHCCCSA had William M. Mercer, Inc. present information regarding the financial costs associated with recently enacted insurance mandates and demographic information on the sub-population of uninsured individuals 45 to 64 years-old, the latter being a group that frequently call legislators. The key focus of the meeting was an update from the Technical Advisory Committee, providing the Task Force with input on potential strategies being considered and setting forth some recommended strategies for the Task Force to consider.

Technical Advisory Committee

The Technical Advisory Committee (TAC) established by AHCCCSA serves in an advisory capacity to both AHCCCSA and the Statewide Health Care Insurance Plan Task Force; providing guidance in the development of plan options as well as feedback on proposed approaches. The TAC is composed of representatives from the physician community, insurance companies (urban/rural, commercial and specialty), hospitals (rural and urban) and state agency directors of AHCCCSA and Department of Insurance. David Griffis serves as a facilitator for the TAC meetings. (See AHCCCS-HRSA project Web site for additional information about the TAC including the meeting minutes).

To date, the TAC has met three (3) times and a brief summary of these meetings is provided below.

- July 18, 2001: At this first meeting of the TAC, background information about the HRSA State Planning Grant, Task Force, consultant projects and role of the TAC was provided. The TAC reviewed the Task Force draft guiding principles and suggested that an additional statement be added under the affordable and properly financed section – "Does the solution foster/encourage consumer responsibility." An initial discussion was begun about current and future health care products and targeted populations.

- August 29, 2001: An overview of recent HRSA grant and Task Force activities was provided. The TAC decided that their goal as a committee should be to focus on the development of strategies which "use available, affordable, financial insurance vehicles to reduce the uninsured population that would not be eligible for public programs." The TAC members, unlike the Task Force did not see purchasing pools as an effective strategy for reducing the number of uninsured. Other issues raised by the Task Force were briefly discussed, e.g., rural infrastructure issues, affordable basic benefit plans, and cost impact of current insurance mandates.

- September 18, 2001: In addition, to David Griffis, a William M. Mercer, Inc. consultant was also used to help facilitate this lengthy strategic planning session. The TAC identified several strategies to address health care coverage for the uninsured population that would not be eligible for public programs. These included implementation of:

  - Community-based education on the value of insurance
  - High-risk pool using multiple funding sources (e.g., public, private and insurance premium funded)
  - Scaled down "basic" benefit plan that would be affordable for working insured and uninsured

  In addition, it was recommended that HealthCare Group, the AHCCCS administered insurance program targeted at small employer groups, be continued with suggested modifications until the other recommended strategies can be implemented. (See AHCCCS-HRSA Web site for a PowerPoint presentation to the Task Force on TAC recommendations).

Future Activities

Other than the final report from the Rural Health Office (RHO) (i.e., Assessment of Arizona's Health Care Coverage Report), the primary focus of the months ahead will be on the development of a plan/framework for the implementation of strategies addressing the issue of accessible, affordable health care in Arizona. This will involve:

- Two (2) or three (3) more Task Force meetings and the development of a final Task Force report by December 15, 2001.
- At least two (2) or three (3) more Technical Advisory Committee meetings involving the further development of possible strategies as well as the identification of other strategies that might be employed to ensure the affordability of insurance for currently insured individuals.
- A series of community meetings and/or focus groups to solicit input on the Task Force recommendations.
- As necessary, more in-depth analysis of possible proposed models/strategies including financial analyses.

Report Format

As directed by HRSA, the remainder of the interim report has been organized according to the State Planning Grant Final Report format, which was provided by the Academy for Health Services Research and Health Policy. This format consists of the following seven (7) sections:

- Section 1. Uninsured Individuals and Families
- Section 2. Employer-Based Coverage

- Section 3. Health Care Marketplace
- Section 4. Options for Expanding Coverage
- Section 5. Consensus Building Strategies
- Section 6. Lessons Learned and Recommendations to States
- Section 7. Recommendations to the Federal Government

The information provided within each of these sections, is directed at responding to the specific questions set forth under each of these sections. As acknowledged by HRSA, not all of the questions are applicable to each individual state's project. Additionally, because this is an interim report, the discussion provided at this time is even more limited. For example, a number of the questions will be able to be addressed once the report assessing health coverage in Arizona is finalized in December or the discussion of possible strategies to be adopted is completed. Information provided in this report covers the grant period of March 1 through September 30, 2001.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

Description of the Uninsured in Arizona

Recent figures released by the U.S. Census Bureau reveal that the percentage of people without health insurance coverage in Arizona has decreased substantially over the past three (3) years from 22.5% in 1998 to 20.0% in 1999 to 16.0% in 2000.[1] This has moved Arizona from having the second highest number of uninsured to having the ninth worst record.

The RHO will be providing more detailed information (e.g., age, income, FPL, race/ethnicity, family work status) about the characteristics of the uninsured population in Arizona as part of their *Assessment of Arizona Health Care Coverage Report*. Also included will be a description of the non-insurance based health programs that primarily are targeted to provide health services to uninsured individuals.

Louis Harris and Associates who were commissioned by the Phoenix-based Flinn Foundation conducted a comprehensive survey on health care in Arizona in 1989 and again in 1995. While the information is six (6) years-old, it does reinforce some of the trends that are currently being identified both within Arizona and other states. For example, the studies found that:

- Most uninsured had been uninsured for two years or longer.
- A predominant characteristic of the uninsured was low-income and not lack of employment.
- There was a decline in the proportion of adults who were uninsured as the size of the employer increased.
- Most uninsured persons cited the cost of insurance as the reason they did not have it, with only 7% saying they "don't want it" and 3% saying they are unable to obtain insurance due to a pre-existing condition.
- In 1995, nearly 60% of the uninsured had not seen a doctor in the prior year with almost half saying that they had put off or postponed getting needed medical care for financial reasons.

More information on these studies can be found on the Flinn Foundation's Web site.[2]

Uninsured Sub-Populations

Some preliminary information regarding the uninsured population in Arizona was provided in the William M. Mercer, Inc. policy issue paper, *Faces of the Uninsured and State Strategies to Meet Their Needs*. This paper identified four (4) key uninsured sub-population groups that due to their size should merit a closer look by policy makers as they craft solutions to health coverage. The identified sub-populations which are not mutually exclusive included:

- Low-Income Uninsured (individuals or family units with incomes below 200% of the FPL): This group represented 74% of the uninsured (ages 0 to 64) in Arizona with 65% being children and their parents.
- Ethnic Uninsured (citizen and non-citizen non-white uninsured): As in other states, wide disparity exists among ethnic and racial groups. The Hispanic population, which comprises 25% of the entire Arizona population represented more than half of the uninsured in Arizona. A key driver that affects the Hispanic uninsured is income.
- Working Uninsured (family units with at least one full-time worker): This group represents 84% of the uninsured population in Arizona. According to Arizona DES Population Statistics Unit, 97% of Arizona's employers consist of fewer than 100 employees.
- Rural Uninsured (family units not living adjacent to a Metropolitan Statistical Area): Using a national perspective, it was noted that individuals living in rural areas of the U.S. have a much higher rate of uninsurance than their urban counterparts. 20% of the uninsured population (ages 0 to 64) in the U.S. live in rural areas with 67% of the uninsured residing in these rural areas having family incomes of less than 200% of the FPL.

In addition to the sub-populations identified above, the Statewide Health Care Insurance Plan Task Force also identified the uninsured pre-retirement group as a sub-population that they were concerned about due to constituent inquiries. William M. Mercer, Inc. presented information to the Task Force members showing that Arizonans ages 45 to 64:

- Represented 24% (1.0 million) of the non-elderly Arizona population (or 20.8% of the total Arizona population)
- Generally had higher incomes than the Arizona population as a whole
- Had 205,000 who were uninsured
- Represented 19% of the non-elderly uninsured population in Arizona.

The Technical Advisory Committee felt that it was important to focus on the sub-population of uninsured individuals who were not eligible for public funded programs. William M. Mercer, Inc. estimated that 50% of the current uninsured population could be covered through publicly funded programs if they applied.

Methodological Approach Used to Collect the Information

As discussed previously, AHCCCSA contracted with the University of Arizona, Rural Health Office (RHO) to compile information regarding health coverage in Arizona. While some primary data sources may be used, RHO will primarily rely on the use of secondary data sources (e.g., Current Population Survey, national surveys, state agency data). A detailed description of the data sources used will be provided in the final report.

An extensive literature review was conducted by William M. Mercer, Inc. in order to produce the report – *Faces of the Uninsured and State Strategies to Meet Their Needs.*

Impact of Findings on Policy Decisions

A discussion of how these findings are reflected in the coverage options considered for adoption by the State will be more thoroughly discussed in the final report.

SECTION 2. EMPLOYER-BASED COVERAGE

Description of Employer-Based Coverage in Arizona

The Commonwealth Fund's 9/8/00 report, *Uninsured and at Risk: Coverage Profiles and Trends among 10 States"* reported that Arizona's higher uninsured rates reflect its lower rates of employer-based health insurance coverage.[3] Only 55% of Arizona's non-elderly population reported employer-based coverage compared with 64% nationally. Also the proportion of Arizona employees who have low hourly wages (i.e., under $10/hour) is higher when compared to the national percentage. Additionally as discussed above in Section 1, the majority of Arizona employers represent small firms (under 100 employees). The primary industry is service (representing 40% of the labor force according to the Census 2000 Supplementary Survey Tables) followed by retail trade (11.5%) and manufacturing (9.9%).[4]

The RHO will be providing more detailed information about employer-based coverage (i.e., characteristics of employees covered and employers offering coverage) in Arizona as part of their *Assessment of Arizona Health Care Coverage Report.* In addition, the report will also summarize the characteristics of populations purchasing private insurance as individuals as well as publicly financed health programs.

Methodological Approach Used to Collect the Information

As discussed previously, AHCCCSA contracted with the University of Arizona, Rural Health Office (RHO) to compile information regarding health coverage in Arizona. While some primary data sources may be used, RHO will primarily rely on the use of secondary data sources (e.g., Current Population Survey, national surveys, state agency data). A detailed description of the data sources used will be provided in the final report.

Impact of Findings on Policy Decisions

A discussion of how these findings are reflected in the coverage options considered for adoption by the State will be more thoroughly discussed in the final report.

SECTION 3. HEALTH CARE MARKETPLACE

Description of Health Care Marketplace in Arizona

A general overview of health care coverage in Arizona is set forth in a series of diagrams that were prepared for the Task Force (See AHCCCS-HRSA Web site for copies of these diagrams). Although lower than the national average, the majority of Arizonans are still covered through employer-based coverage. It has been estimated that approximately 13% of Arizonans are covered through publicly funded income-based programs (i.e., Title XIX/XXI). As of 10/01/01, 657,490 Arizonans are enrolled in AHCCCS. In addition to the publicly supported programs, the State of Arizona also is the largest employer in the state currently employing 59,348 individuals. Out of these employees, approximately 54,000 are enrolled in the State's health plan through CIGNA HealthCare of Arizona.

Unlike many other states, the Arizona health care marketplace made the shift from indemnity insurance to managed care (i.e., with 31% in managed care in 1989 and 52% in 1995 – Flinn Foundation study). This is further exemplified by the fact that almost all individuals who are enrolled in the AHCCCS programs (i.e., Title XIX/XXI) receive their health care through HMOs. This same phenomenon is also reflected in the Medicare managed care market, especially in the urban marketplace (i.e., 42% of Medicare beneficiaries in Phoenix were enrolled in Medicare+Choice plans).[5] In May, the Arizona Department of Insurance reported that there were 240,000 seniors enrolled in Medicare+Choice plans.

Over the past decade, Arizona has taken a number of steps to address the adequacy of health coverage in the State through health care market reform. This reform has involved both public as well as private sponsored reform; primarily targeting low-income, chronically ill and small employer groups. Examples of this include:

- HealthCare Group, implemented in 1988, offers affordable and accessible health care coverage to small businesses with 50 or fewer employees. Since 1999, HealthCare Group receives an annual state subsidy of up to $8 million.
- Small group market insurance reforms beginning in 1993 made insurance more available and affordable for small employers.
- Premium Sharing Program, implemented in 1998 provides health care coverage to a limited number of uninsured individuals with income up to 250% of FPL or below 400% of FPL, if chronically ill.
- KidsCare (Title XXI), implemented in 1999, to provide coverage to S-CHIP eligible children up to 200% of FPL.
- Voter passed initiatives to target use of 70% of tobacco tax monies for health care to low-income uninsured groups (passed in 1994) and the expansion of AHCCCS coverage to all Arizonans below 100% of FPL through the use of tobacco settlement monies (passed in 2000). (See section below on recent public program expansions)

The RHO will be providing more detailed information about the overall health care marketplace in Arizona as part of their *Assessment of Arizona Health Care Coverage Report.* In addition to the information on the uninsured and employer-based coverage, the report will summarize:

- The characteristics of individuals purchasing private insurance.
- The types of publicly financed health programs and the characteristics of the populations eligible for these programs.
- The cost of health insurance for individuals covered by employer-based insurance, private insurance individually purchased and public subsidized insurance with the primary focus being on the cost of premiums and the required contributions by involved parties.

AHCCCSA contracted with William M. Mercer, Inc. to analyze the Arizona Basic Health Benefit Plan in the context of other states' approaches and critique the plan in terms of benefit design variables as well as its overall affordability. In *Arizona Basic Health Benefit Plan: A Comprehensive Review*, Mercer found the Arizona Basic Health Benefit is:

- Not basic
- Not targeted at the uninsured
- Not affordable
- Not attractive since consumers are currently not showing much interest in purchasing the product.

Recent Marketplace Trends

Like the rest of the nation, the Arizona health care marketplace is currently in a period of flux as health care costs continue to rise and the financial viability of some health care organizations continues to be threatened. The Center for Health System Change recently released their 2000 Community Tracking Study on the Phoenix health care market.[5] This report, despite its limited geographic focus does provide some valuable information regarding recent trends in the State's health care marketplace, many of which are applicable statewide. Some key trends that are noted in the report include:

- Consolidation of hospital systems; giving them more of a significant advantage in negotiations with health plans in geographic areas in which they have monopolies.
- Increase in physician discontent as reflected by the movement of specialists to specialty facilities and physicians refusing to enter into risk contracts.
- Increase in premiums and elimination of unprofitable or marginal lines of business to improve health plans financial conditions.
- Decrease in the number of Medicare+Choice health plans with those remaining requiring seniors to contribute more to the cost of care.
- Potential for deterioration of the local safety-net, which has been relatively stable over the past years.

These marketplace trends are further exemplified by a number of key events which have been recently reported in the local news. These include:

- Several health plans pulling out of the Medicare+Choice program, i.e., Aetna in Maricopa County (6200 enrollees), Pacificare in southern Pinal County (4100 enrollees) and several reducing benefits, e.g., Health Net Inc. and Humana Inc. This leaves only 3 out of 15 counties with Medicare+Choice plans.
- United Healthcare in Arizona dropping its individual health insurance product (7500 enrollees) in order to help regain profitability.
- The announced closing of the only two (2) trauma centers in Tucson; leaving southern Arizona without any top level trauma centers after the end of the year.
- Loss of $9.4 million in the past six(6) months by HMOs in Arizona with only two (2) out of six (6) of the major plans posting gains.
- Reported increases this year in health care premiums of 15 to 45 percent; largely attributable to the posted losses in Arizona's managed-care companies.
- Reduction in employee choice of plans and out-of-pocket expenses, e.g., State of Arizona switched to one insurer to provide coverage to all state employees; at the same time increasing employee share for premiums and co-pays.

The health care marketplace was also impacted by the enactment in 1999 of a state HMO reform law which gave patients various rights to appeal their health plan decisions. Part of this law expanded the number of legislatively mandated benefits. AHCCCSA contracted with William M. Mercer, Inc. to conduct an independent cost study to estimate the financial impact of health insurance mandates recently enacted by the 1999 HMO reform law. The study considered mandates in six (6) areas: administration, access to medical supplies, pharmacy, direct access to care, emergency services and clinical trials. Taken together the estimated impact of the enacted mandates was a 5.7% increase in health care premiums. Direct access to chiropractic services had the greatest cost impact at 3%. (See the AHCCCS-HRSA Web site for a complete copy of the report which is entitled *Financial Impact of Recently Enacted Health Insurance Mandates*.)

Recent Public Program Expansions

As the result of recent state legislation, AHCCCSA is expanding the role of public sponsored programs through both the implementation of new programs as well as the expansion of current programs. These changes include the following:

- Implementation of Proposition 204 on 10/1/01 which amends AHCCCSA's 1115 waiver and establishes Title XIX eligibility up to 100 % of FPL for individuals without children. It also has a spend-down component (e.g., MED) that enables individuals who have incurred medical bills to use those bills to spend down their income and become eligible for health care. Additionally, as part of the implementation of these groups, AHCCCSA is streamlining eligibility.
- Expansion of Title XIX eligibility for families with children through a State Plan Amendment which raises income eligibility for 1931 Title XIX eligibility group up to 100% of FPL beginning 7/1/01.

- Expansion of Premium Sharing Program from a four (4) county pilot to a permanent statewide program. Funding level for the program is an annual appropriation of $20 million.
- Modifications to KidsCare program, effective 10/1/01 which expands the benefit package (i.e., adds non-emergency transportation, removes eyeglass/exam and behavioral health limitation) and reduces the bare period from six (6) to three (3) months with the ability to waive if a child is seriously/chronically ill.
- Implementation of a state-funded Prescription Drug Pilot Program on 11/1/01 which reimburses 50% of the cost of prescription medication in excess of a deductible for individuals who qualify for Medicare, have income levels between 100% to 200 % of FPL and who reside in counties with Medicare plans that do not offer a Medicare HMO pharmacy benefit. Two (2) year funding is limited to approximately $4 million per year.
- Implementation of Ticket to Work on 4/1/02 which adds a new optional Title XIX eligibility group of individuals, 16 to 64 years of age who meet the SSI disability requirement and have earned income below 250% of FPL.
- Implementation of Breast and Cervical Cancer Treatment on 1/1/02 which adds a new Title XIX eligibility group of women under 65 who have been screened by Arizona Department of Health Services (ADHS), have no insurance and need treatment for breast and/or cervical cancer.
- Submission of a waiver to Centers for Medicare & Medicaid Services (CMS) for approval to cover S-CHIP parents with family income up to 200 % of FPL. If approved by CMS, the State will need to appropriate the state match for the expansion and legislatively authorize the coverage.

As a result of the Title XIX program expansions, especially implementation of expanded Medicaid eligibility under Proposition 204 and the 1931 children and family group as well as a slowing economy, AHCCCSA is currently projecting a 20% growth in the AHCCCS population, which currently has 682,929 members. It has been estimated that between 130,000 to 180,000 individuals will be added to the AHCCCS program as a result of Proposition 204.

Rural Health Care Infrastructure

In order to more appropriately identify the issues that surround the development of a strong rural health care infrastructure, AHCCCSA sought to provide the Task Force with additional information regarding the issue of rural infrastructure strategies. This effort resulted in:

- A policy brief by William M. Mercer, Inc., *Initiatives to Improve Access to Rural Health Care Services*, which found:

    - Information showing that rural uninsured tend to be employed by small employers, reside in households with at least one full-time worker, are older, younger and poorer and have fewer provider network choices.

- Identification of key barriers include: lack of physicians and other providers, geographic isolation and hospital solvency issues (i.e., insufficient volume to justify size and capabilities).
- Discussion of strategies employed by other states to address rural infrastructure concerns and provisions including: financial and technical assistance to make rural areas more attractive to practitioners, examples of collaboration between health and non-health resources and/or urban and rural resources, changes in reimbursement methodologies for hospitals, and creative use of hospital space and resources.

- An AHCCCSA prepared document, *Inventory of Arizona Strategies to Address Rural Health Care Infrastructure*, provides a comprehensive description of specific strategies/programs that have been implemented in Arizona. These strategies have been grouped according to those which:

  - Increase the number of rural practitioners
  - Minimize geographic isolation
  - Improve the viability of health care facilities
  - Financially support rural-based health care service programs

Other States' Experiences

Other states' experiences, along with international approaches to health care delivery, have and continue to be considered as part of the policy deliberation regarding health care coverage in Arizona. In order to educate policy makers regarding experience outside of Arizona, AHCCCSA contracted with Milliman USA, Inc. to produce four (4) policy issue briefs. These reports were distributed to both the Task Force and Technical Advisory Committee and discussed at subsequent meetings of the groups. A summary of the findings from these papers is provided below:

- *Purchasing Pools* found:

  - Historically, challenges faced by pools have involved: low employer enrollment, lack of health plan participation, unwillingness of agents to promote, adverse selection, and the inability to offer PPO and POS plans.
  - Need to substantially increase the enrollment in pools in order to be viable and be able to offer lower prices.
  - Not able to lower prices enough to encourage more small employers to offer insurance without significant subsidies or mandates.

- *High-Risk Pools* found:

  - Risk pools play a major role in making coverage available to uninsurable individuals, reducing the number of uninsured and providing stability to the health care market.

- A key issue in establishing a high-risk pool is to make sure that it is well-funded including revenue sources besides premiums and assessments.

- *Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage* found:

  - S-CHIP and premium sharing programs have been successful in enrolling targeted populations, although crowd-out may be a concern.
  - Tax credits and deductions are questionable for the uninsured and may be more appropriate to discuss at federal levels.
  - Small group market reform has led to stability, more readily available and more predictable cost increases, but has not addressed the affordability issue and has had little or no impact on the number of uninsured.
  - Individual market reform has not been successful in reducing the number of uninsured.
  - Programs which are successful in reducing the number of uninsured generally involve some expenditure of public funds.

- *International Approaches to a Socialized Insurance System* found:

  - These systems are largely reliant on taxation, highly regulated, place a significant emphasis on preventative care, require co-pays and ration care through waiting lists.
  - To implement this type of system in US/Arizona, one would need significant increases in taxes to cover the uninsured, mandatory employer-based coverage, ERISA exemption, more uniformity of benefits, more regulation of provider fees, restrictions on patient choice of provider and income-based differentiation of benefits and/or contributions.

Methodological Approach Used to Collect the Information

As discussed previously, AHCCCSA contracted with the University of Arizona, Rural Health Office (RHO) to compile information regarding health coverage in Arizona. While some primary data sources may be used, RHO will primarily rely on the use of secondary data sources (e.g., Current Population Survey, national surveys, state agency data). A detailed description of the data sources used will be provided in the final report.

For the other reports highlighted in this section the following methodological approaches were used to collect the information contained in the reports:

- *Arizona Basic Health Benefit Plan: A Comprehensive Review*: Literature review and interviews with state programs or Mercer staff responsible for employer-sponsored health coverage in selected states.
- *Financial Impact of Recently Enacted Health Insurance Mandates*: Literature review, e.g., Congressional Budget Office estimates and sound actuarial assumptions and methods.

- *Initiatives to Improve Access to Rural Health Care Services:* Literature review and discussions with staff from various state programs.
- *Inventory of Arizona Strategies to Address Rural Health Care Infrastructure*: Literature review and interviews with persons who staff various rural health care programs and/or are considered to be local experts in the area of rural health care delivery.
- The four (4) Milliman USA Inc. policy issue papers, discussed earlier in the Other States' Experience section above: Literature review as well as consultant experience from work on various programs.

Impact of Findings on Policy Decisions

A discussion of how these findings are reflected in the coverage options considered for adoption by the State will be more thoroughly discussed in the final report.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

At this time, there a have not been any specific policy options selected for expanding health care coverage. The primary focus in the months ahead will be on the development of a plan/framework for the implementation of strategies addressing the issue of accessible, affordable health care in Arizona.

Given the current budget shortfalls in the State, it is very unlikely that any recommended strategies that involve the appropriation of new state funds will be supported at this time. In fact, at the last Task Force meeting, the Task Force chairperson pointed out that it is important for persons to recognize that there is a budget crisis in the State. Therefore, while it may not be possible to immediately implement agreed-upon strategies; there is a strong commitment to develop a plan as to how the system should look and then to build that system over time.

Additionally, the focus of the recommended strategies is likely to look at how best to either ensure that health care coverage is affordable, accessible to those individuals who are not eligible for public programs and/or for those who may currently be insured but for whom affordability is a growing concern. While expansion of public programs (e.g., Title XIX/XXI) may still be a consideration, it will probably not be a primary focus at this time because the State recently took a number of steps to greatly expand coverage through AHCCCSA (see discussion in Section 3 under Recent Public Program Expansions).

Preliminary Considerations

As a result of the presentations on the seven (7) policy issue papers commissioned by AHCCCSA, members of the Statewide Health Care Insurance Plan Task Force discussed possible strategies for addressing the issue of health care coverage in Arizona including:

- Targeting of small employer groups, individuals residing in rural areas of the state, and the pre-retirement group
- Development of purchasing pools potentially building upon the existing HealthCare Group program
- Development of a high-risk pool
- Development of additional strategies to address health care infrastructure issues in rural areas of the state

The Technical Advisory Committee (TAC) discussed the Task Force suggested strategies and held initial discussions regarding strategies which would involve the use of available, affordable, financial insurance vehicles to reduce the uninsured population that are not eligible for public programs. Preliminary recommendations that the TAC presented at the September Task Force

included the following (see AHCCCS-HRSA Web site for a PowerPoint presentation to the Task Force on TAC recommendations.):

- Initiation of community-based education on the value of insurance.
- Implementation of a high-risk pool for high cost/uninsurable individuals using multiple funding sources (e.g., public, private and premium funded).
- Development of a scaled down "basic" benefit plan that would be affordable for working insured and uninsured (Pointing out that the current basic health benefit plan is not basic, is not affordable and is not targeted at the uninsured or working insured).
- Adoption of proposed modifications to HealthCare Group; continuing to support this program until such time that the other marketplace reform strategies can be implemented.

As to the reliance on the use of purchasing pools, which is of great interest to the Task Force, the TAC noted that the ability to form purchasing pools exists in statute. Instead of focusing on the development of purchasing pools, the TAC members felt that the discussion should center on the development of an affordable health care insurance product. TAC members noted that affordability is primarily driven by the benefit package design.

The TAC will be meeting again in early November in order to further develop these initial recommended strategies as well as identify other strategies that might be employed to ensure the affordability of insurance for currently insured individuals. Subsequent meetings of the Task Force are being planned for November and December.

Title XIX/XXI Outreach and Enrollment Strategies

Over the past several years, AHCCCSA has made a concerted effort to address the issue of eligible but unenrolled individuals in its Title XIX/XXI program. William M. Mercer, Inc. estimated that as many as 50% of the uninsured may be eligible for these publicly supported programs. The strategies employed by AHCCCSA have involved both implementation of new outreach programs as well as changes in enrollment processes. A brief discussion of these strategies is provided below.

<u>AHCCCS/Community Based Organization Outreach Project</u>

AHCCCSA has taken a statewide grass roots approach to outreach by contracting with seven (7) community based organization (CBO's), e.g., county health departments, Association of Community Health Centers, and other provider organizations. The CBO's perform outreach to schools, clinics, CBO's, physicians, churches, tax preparers, day care centers and other sites. Their community partners educate potentially eligible families and children about the availability of all AHCCCS programs and assist them in applying for AHCCCS services. The total combined contract amount for all seven (7) CBO's is $1 million and includes funding of 35.5 outreach positions.

AHCCCS Outreach Activities

In addition to the CBO project described above, AHCCCSA has implemented a number of other outreach activities particularly targeted at individuals who may be eligible as a result of the various AHCCCS program expansions. These activities include:

- A special $900,000 intensive six (6) month ad campaign for the KidsCare program which included radio, TV, brochures, posters and billboards conducted earlier this year
- Radio advertising, bus shelter billboards and brochures targeted at the new eligibility groups under Proposition 204; including the 1931 eligible family and children group
- Kiosk boards in malls where seniors walk in order to let them know about Title XIX and the enhanced benefits available under Title XIX
- Sponsorship of events such as the Wellness Expo in Phoenix in November

All of the written materials and verbal announcements are provided in both English and Spanish.

Streamlining of Eligibility Processes

As part of the recent program expansions, AHCCCSA has also taken a number of key steps toward addressing the ongoing goal of streamlining the Title XIX/XXI eligibility process. This includes the following:

- Universal AHCCCS Application. Instead of separate applications for each program, a universal application has been adopted, which is used to determine whether a person is eligible for any AHCCCS related program.
- Mail-in Applications. Effective 10/1/01 applicants are no longer required to come in for a person to person interview at a local Department of Economic Security office.
- Centralized Screening Office. A centralized screening office has been established at which AHCCCS and DES staff are co-located in order to help facilitate the processing of eligibility.
- Consolidation of Eligibility Entities. The counties will no longer be responsible for making eligibility determinations since eligibility functions are centralized at either DES or AHCCCS depending on the eligibility group.
- Redeterminations are conducted less frequently, by lengthening the redetermination period from six (6) to 12 months (except for the medical expense deduction group).

KidsCare Eligibility

With the implementation of the S-CHIP program in Arizona, the State was required to screen S-CHIP applicants to determine if they would be eligible for Title XIX prior to enrolling them in KidsCare. As a result, AHCCCSA has experienced a wood work effect (people who are eligible for a program but not enrolled until they "come out of the wood work" to apply for another

program). Although 53,000 kids are enrolled in KidsCare, there are actually almost 120,000 children who now have health insurance as a result of the KidsCare program.

SECTION 5. CONSENSUS BUILDING STRATEGIES

The very nature of the way in which the Arizona State Planning Grant was structured lends itself to a process by which one can effectively build consensus around any proposed strategies. This is reflected both in the governance structure as well as the methods being used to obtain key stakeholder input.

Governance Structure

The governance structure for the Arizona State Planning Grant effectively involves the executive branch, the legislative branch, and a variety of key constituent groups in the planning process. This is reflected by the following:

- Governor of Arizona identified AHCCCSA, the state's Medicaid agency and overseer of a number of other subsidized insurance programs as the lead project agency.
- Through the grant, AHCCCSA is providing technical and staffing support to Arizona's Statewide Health Care Insurance Plan Task Force, a legislatively sponsored committee, which is playing a key role in designing an accessible and affordable health care coverage plan; including the identification of recommended strategies to be implemented. There are six (6) legislators on this committee representing both rural and urban districts in the State. In addition, other key constituent groups are represented on the Task Force including a member who is a health care provider, a representative of a consumer advocacy group and a member who represents the business community. These three members were appointed by the Governor.
- Key constituent input through the establishment of the Technical Advisory Committee which is composed of representatives from the physician community, insurance companies (urban/rural, commercial and specialty), hospitals (rural and urban) and state agency directors of AHCCCSA and Department of Insurance. This Committee is providing AHCCCSA and the Task Force with guidance in the development of options as well as feedback on proposed strategies.

Stakeholder Input

In addition to the various constituent groups that are part of the governance structure, there are a number of other approaches that are/or will be employed in order to ensure that there are adequate opportunities for stakeholder input. To begin with, all of the Task Force meetings are public meetings and are subject to the open public meeting laws. To date the Task Force meetings have been very well attended (i.e., approximately 50 attendees) with representatives from insurance carriers, retirement groups, advocacy agencies, employee unions, hospital association, and county governments.

At this time, AHCCCSA is planning to hold a series of community meetings once the Task Force has identified various strategies that they feel should be considered for adoption. These meetings would be held throughout the State, specifically targeting rural areas. While anyone will be welcome to attend these meetings, individuals who will be specifically targeted include, local community service agencies (i.e., safety-net providers), medical community, tribal government, and local advocacy groups**.** Additionally, AHCCCSA is also planning to conduct focus groups with representatives from small group employers. These meetings are tentatively scheduled for January.

Other Public Awareness Strategies

In order to facilitate the public's easy access to AHCCCS-HRSA State Planning Grant information and project materials, AHCCCSA has established a Web site (see www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA). On this Web site, one can find general descriptive information about the project, Technical Advisory Committee minutes, policy issue papers, Task Force guiding principles, project contacts and links to state/federal related Web sites.

In addition to establishment of the Web site, AHCCCSA has made several public presentations regarding the AHCCCSA-HRSA State Planning Grant. This has included:

- Presentation and participation on a panel at the annual Arizona Rural Health Conference entitled "*Building Rural Health Networks*". Over 100 individuals attended this session; representing a diverse interest group, e.g., local community provider agencies, state officials, Indian tribes, and county public health departments.
- Presentation at a meeting of the four (4) Arizona Community Access Program grantees and one (1) rural Health Network Development Project grantee.

Current "Policy Environment"

As mentioned in Section 4, the State of Arizona has a severe budget shortfall, which will have an enormous impact on the type of coverage expansion strategies that will be adopted in the State in the near future. Some analysts have estimated that the deficit could go as high as $1.6 billion over the next two (2) years. Given this situation, the State in addition to cutting state agency budgets is aggressively looking for strategies that will allow maximization of current state dollars as well as re-evaluating current commitments to continue to fund certain programs (e.g., substance abuse treatment and religion programs for inmates) or delay implementation/funding of other programs (e.g., replacement of obsolete equipment and provider rate increases).

Given this budget shortfall, the Task Force chairperson, stressed that the Task Force should focus on development of a plan suggesting how the system should look with the expectation that the system will be built over time.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

Since that the project work is only partially completed at this time it is still relatively premature for AHCCCSA to definitively be able to articulate those "lessons learned" in designing a plan or in the policy planning process itself. However, at this time there are a few observations which can be provided in the area of data collection and consensus building.

Data Collection

Unlike most other State Planning Grant states, Arizona made a conscious decision up front not to put as heavy an investment in the collection of extensive primary data regarding current coverage and coverage barriers (e.g., statewide surveys and focus groups). There were several reasons for this decision. It was felt that while it was important to be able to understand the current health care coverage landscape, grant monies also needed to be available for the gathering of information on other states' experiences, educational materials on health coverage issues, in-depth analysis of any proposed strategies, including the financial analysis and solicitation of stakeholder input on the potential strategies. In trying to balance out the various needs, an extensive state specific survey was ruled out due to the high cost and long length of time associated with it. Instead, it was decided that an adequate picture of the current landscape could be obtained through existing data sources, e.g., national surveys and local data sets. Additionally, through literature reviews (e.g., national studies as well as other states' data surveys) fairly consistent patterns have been emerging in terms of health coverage demography and coverage issues. Lastly, since the project focus was the development of a plan at the state level it was felt that despite recognized data limitations, reliance on secondary data sources would result in an accurate enough picture with which to be able to make appropriate decisions.

While beyond the scope of Arizona's project, the results of a recent study funded by the Phoenix-based Flinn Foundation (i.e., Yuma Project on Uninsured Children) may be of interest to other states focusing on specific strategies targeted at the local community level.[6] This study found that a community health data system as opposed to survey data can be used to provide accurate estimates of the numbers of uninsured children in small geographic areas and at a relatively low cost. This community data is also dynamic in that it can be continuously updated at a relatively low cost; providing unique information on health coverage at points in time and on patterns of health care utilization and changes in needs and insurance over time.

Consensus Building

Given the complex nature of the issue, it has already become apparent that an absolute critical need is to spend time educating the key policy makers in the state (e.g., legislators and key

constituent groups). The approach of using both a legislatively formed Task Force balanced with a Technical Advisory Committee appears to offer a good balance between the political decision making process and more expertise-based decision making.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

As noted in Section 6, it is still relatively premature for AHCCCSA to definitively articulate any specific recommendations to the federal government at this time. Clearly, funding of coverage expansion options is going to be a continuous issue and that any assistance that the federal government can provide in terms of addressing the issue of funding will enhance the State's ability to address the issue of health care coverage. Additionally, the federal government should continue to fund initiatives such as the State Planning Grant as states on their own do not have the ability to carry out the in-depth analysis that these grants allow. It is also already becoming apparent that a one year grant is very limited and consideration should be given to providing states with a second year of support in order to be able to effectively develop and/or implement proposed strategies.

APPENDIX I: BASELINE INFORMATION

Population

According to the Census 2000 Supplementary Survey, Arizona's total population in 2000 was 5,020,782.[7]

Number and Percentage of Uninsured (Current and Trend)

In Arizona, the percentage of people without health insurance coverage has decreased over the past three (3) years. According to the U.S. Census Bureau, in 1998, 22.5% of the population was uninsured; in 1999, 20.0% of the population was uninsured; and in 2000, 16.0% of the population was uninsured. The 3-year average from 1998-2000 is 19.5%.[1]

Average Age of Population

As noted by the Census 2000 Supplementary Survey, the median age in Arizona is 34.3 years-old.[7]

Percent of Population Living in Poverty (<100% FPL)

The Census 2000 Supplementary Survey reported that 15.6% of Arizona's population is living below poverty level. For people over 18 years and older, 13.1% are below poverty level. For people who are 65 years and older, 9.5% are below poverty level. For related children under 18 years, 22.0% are below poverty level. For related children under 5 years-old, 25.3% are below poverty level. For related children five (5) to 17 years, 20.8% are below poverty level. For unrelated individuals 15 years and older, 23.0% are below poverty level.[4]

Primary Industries

The Census 2000 Supplementary Survey also reported that the three primary industries in Arizona in order from highest to lowest are: services, retail trade, and manufacturing. [4]

Number and Percent of Employers Offering Coverage

The Health Insurance Component Analytical Tool (MEPS) reported that in 1998, there were 93,910 private-sector establishments in Arizona. Of the 93,910 employers, 50,430 (53.7%) of them offered health insurance.[8]

Number and Percent of Self-Insured Firms

In 1998, there were 27,234 (29.0%) private-sector establishments in Arizona that offer health insurance that self-insure at least one plan according to MEPS.

Payer Mix

The US Census Bureau estimated that in 1999, 78.8% of the Arizona population had health care coverage. 55.9% were covered by an employer-sponsored plan, 7.9% were covered by individually purchased private insurance, 8.8% were covered by AHCCCS, 12.9% were covered by Medicare, and 5.9% were covered by other federal programs.

Provider Competition

The Winter 2001, *Community Report* summarizes the recent provider competition among hospitals, physicians, and health plans in Phoenix. As a result of the rapid growth, national firms now control 70% of the Phoenix community's hospital capacity, as well as dominate the health plan market. Many hospitals are trying to affiliate themselves with national systems in order to come up with capital necessary to keep up with the increase in demand (e.g., the merger between Samaritan Health System, the area's largest provider system, and the national Lutheran Health Network to form BannerHealth Arizona). Many hospitals focus their strategies on certain geographic areas, which helps them to secure better contract terms and higher payment rates. As a result, this also limits health plans' ability to hold down costs.

The report also notes the shifting of physicians from traditional hospitals to specialty facilities. Due to their discontent with local health care systems and desire for higher incomes, physicians are leaving traditional hospitals with the loss of profitable services. In addition, hospitals are finding it increasingly difficult to provide emergency room and on-call coverage as physicians attempt to avoid seeing uninsured patients for whom they will not be reimbursed. This has led to some specialists forming arrangements to demand above-market reimbursement. The relationship between physicians and health plans has also become more difficult as physicians are refusing to enter into risk contracts, and health plans are reverting to fee-for-service payment.

Out of the ten (10) HMOs currently operating in Phoenix, only two (2) of those have reportedly been profitable. In an attempt to become more profitable, plans have been increasing premiums and eliminating unprofitable or marginal lines of business. As a result of the struggle for profitability, several health plans are pulling out of the Medicare+Choice program, which has left only three (3) out of 15 counties with Medicare+Choice plans. Low profitability and recent regulations may be why many consumers have seen higher costs and fewer choices.

Insurance Market Reforms

The Arizona Department of Insurance (DOI) has compiled the following information on insurance market reforms. There have been several key health care insurance reforms in Arizona over the last eight (8) years. In 1993, the legislature enacted the Accountable Health Plan Law, which was aimed at improving the availability of group health insurance to small employers.

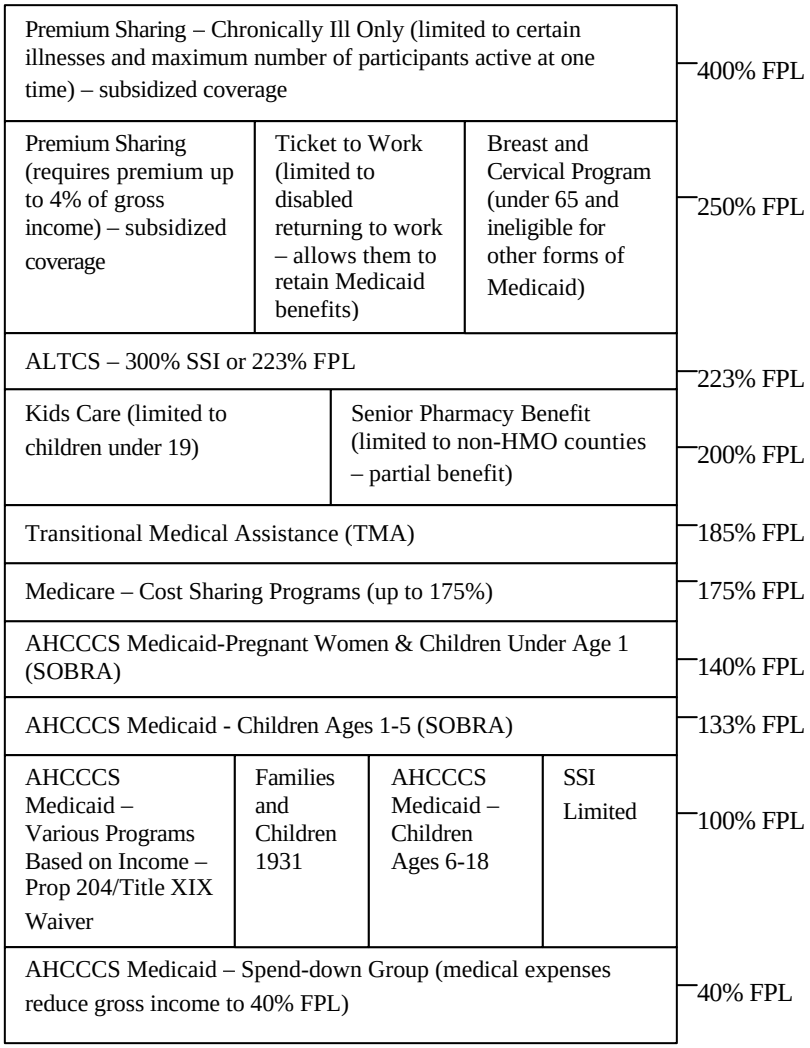
Effective January 1, 1994, group health insurers (accountable health plans) were required to offer at least a basic health benefits plan to employers, including small employers. The legislation phased in elements of guaranteed issue with later effective dates. Specifically, effective July 1, 1994 an accountable health plan was required to make the basic health benefits plan available to employers with 25 to 40 employees who had been without coverage for at least 90 days. Effective July 1, 1996, an accountable health plan was required to make the basic health benefits plan available to employers with three (3) to 40 employees who had been without coverage for at least 90 days.

While the 1993 legislation improved the availability of group health insurance to small employers, it only provided such coverage on a guaranteed issue basis for a certain small employers and their employees. Legislation that became effective July 1, 1997 required an accountable health plan to provide a health benefits plan, without regard to health status-related factors, to any small employer who agreed to make the required premium payments. As part of this legislation the definition of "small employer" was revised to include any employer with two (2) but not more than 50 employees, the basic health benefit plan was eliminated and all small employers are entitled to guaranteed issue, not just those that have been without coverage for at least 90 days. This legislation conformed to federal guaranteed availability requirements established in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In addition, in 2000, the Arizona legislature passed legislation restructuring the regulatory oversight of managed care organizations, mandating additional health care benefits and establishing timely pay and grievance standards for payment of health care providers.

Eligibility for Existing Coverage Programs

Please see the chart on the following page for eligibility levels for income-based programs:



Use of Federal Waivers

Arizona became the last state in the nation to implement a Medicaid program. In October 1982, Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS) was started under a 1115 Research and Demonstration Waiver granted by the Health Care Financing Administration (HCFA). From 1982 until 1988, AHCCCS only covered acute care services, except for a 90-day post-hospital skilled nursing facility coverage. Then, in 1988, a five (5) year extension of the program was approved by HCFA to allow Arizona to implement a capitated long-term care program for the elderly, physically disabled, and developmentally disabled populations – the Arizona Long Term Care System (ALTCS). In 1990, AHCCCS began offering comprehensive behavioral health services, eventually extending behavioral coverage to all Medicaid eligible persons over the next five years. Since then, a number of waiver extensions have been approved, with the most recent one being a three (3) year waiver extension for the period from October 1, 1999 through September 30, 2002.[9]

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

The key Web Site to use for additional sources of information regarding the AHCCCS-HRSA State Planning Grant is www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA.

NOTES

1. "Health Insurance Coverage: 2000 Consumer Income" Current Population Reports by Robert J. Mills from U.S. Census Bureau [database online] (Issued September 2001 [cited 16 October 2001]); available from http://www.census.gov/hhes/www/hlthin00.html.

2. "Health Care in Arizona, 1995 vs. 1989" Studies of Health Care in Arizona by Louis Harris and Associates [online] (published in 1996 [cited 16 October 2001]); available on the Flinn Foundation Web Site from http://www.flinn.org/news/reports/.

3. "Uninsured and At Risk: Coverage Profiles and Trends Among 10 States." Task Force on the Future of Health Insurance. Prepared for the National Summit on the Uninsured September 8, 2000; available from the Commonwealth Fund by calling 1-888-777-2744.

4. "Profile of General Selected Economic Characteristics: 2000." Census 2000 Supplemental Survey Summary Tables [database online] (2000 [cited 16 October 2001]); available from http://www.factfinder.census.gov/servlet/BasicFacts/servlet.

5. Draper, Debra, et al. Rapid Population Growth Attracts National Firms, Phoenix Arizona. Community Report, No.04 (Washington, D.C.: Center for Studying Health System Change, Winter 2001).

6. School of Health Administration & Policy, College of Business, Arizona State University, "The Yuma Project on Uninsured Children", Report to the Community. September 17, 2001.

7. "Profile of General Demographic Characteristics: 2000." Census 2000 Supplemental Survey Summary Tables [database online] (2000 [cited 16 October 2001]); available from http://www.factfinder.census.gov/servlet/BasicFacts/servlet.

8. "Health Insurance Component Analytical Tool (MEPSnet/IC)" Agency for Healthcare Research and Quality, Rockville, MD. [database online] (January 2001 [cited 16 October 2001]); available from http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.asp.

9. "Arizona Statewide Health Reform Demonstration: Fact Sheet" Health Care Financing Administration Web site [database online] [cited 16 October 2001]; available from http://www.hcfa.gov/medicaid/1115/azfact.htm.